The Institute of Plastic Reconstructive and General Surgery

Quang Tu, M.D. BaoLien Tu, M.D.

PATIENT REGISTRATION INFORMATION

Name: (Last, First, MI) ____ **Gender:** ☐ **F** ☐ **M**

Date of Birth: _____/_____/_____ **Age:** ________________ **Marital Status:** ☐ **M** ☐ **S** ☐ **W** ☐ **D** ☐ **DP**

Address: ____ **Social Security #:** _____/____/_____

City: ________________________ **State:** _______ **Zip Code:** ___________ **Email:** ___________________________________

Home Phone: _______________________ **Cell Phone:** _______________________ **Work Phone:** ______________________

Place of Employment: ____ **Job Title:** _______________________________

Primary Care Physician: ____ **Phone:** ______________________

Referring Physician: ____ **Phone:** _____________________

HOW DID YOU HEAR ABOUT OUR OFFICE? ____

GUARANTOR/RESPONSIBLE PARTY/LEGAL GUARDIAN

Name: ____ **Relationship to Patient:** __________________________

Address: ____ **City:** __________________ **State:** _______ **Zip Code:** _________

Social Security #: _____/____/_____ **DOB:** _____/_____/_____ **Phone:** ___________________ **Work:** __________________

Employer: ____

PRIMARY INSURANCE

Policy Holder: __________________________________ **DOB** ___/___/___ **Employer Name:** __________________________

Insurance Company Name: __________________________________ **Phone Number:** _______________________________

Policy/ID Number: _____________________________________ **Group Number:** ___________________________________

SECONDARY INSURANCE

Policy Holder: ___________________________________ **DOB** ___/___/___ **Employer Name:** __________________________

Insurance Company Name: ___________________________________ **Phone Number:** ______________________________

Policy/ID Number: _______________________________________ **Group Number:** _________________________________

EMERGENCY CONTACT INFORMATION

Spouse/Partner: ___________________________________ **Phone:** __________________ **Work Phone:** __________________

Emergency Contact: ____ **Relationship to Patient:** _______________________

Phone: _________________________ **Cell Phone:** _________________________ **Work Phone:** ________________________

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PATIENT FINANCIAL POLICY – CONSENT TO TREAT – RELEASE OF INFORMATION

Thank you for choosing The Institute of Plastic, Reconstructive and General Surgery for your medical care. The physicians and staff at The Institute of Plastic, Reconstructive and General Surgery strive to provide superior services to all of our patients. Services provided by our physicians, medical staff, non-medical staff and billing service are carried out with the highest level of ethicality, professionalism and cost efficiency for all of our patients. Our patients are an important part of their healthcare success. Please read the following policies and informational pieces to help us reach our goal for your care.

FINANCIAL POLICY

Our Physicians are contracted with most major insurance carriers, in addition to Medicare, Medicaid (Soonercare), and Tricare.

The Institute of Plastic, Reconstructive and General Surgery file claims to the insurance companies as a courtesy to our patients. However, payment of copayment, deductible and coinsurance responsibilities are due at the time of service.

It is the patient's responsibility to make sure we have the correct and most recent insurance information on file.

It is also the responsibility of the patient to make sure any authorization or precertification/referral is obtained before the date of the appointment. Any surgery recommended by the physicians will not be scheduled until authorization is obtained.

It is the policy of this practice to collect any financial responsibility at the time of service. Cosmetic/Elective Surgery payments are due at least 10 days prior to surgery. We accept Cash, Check, Visa, Master Card, American Express, Discover and Care Credit for your convenience.

We do not mind completing forms for medical leave, deferred payments, reimbursement policies etc. However, there is a $25 charge per form. Payment is due at the time the form is left for completion.

Checks returned to our office by a bank or credit union will be accessed a $25 return check fee.

The patient or guarantor is responsible for any and all services not covered by the insurance company.

I have read and understand the Financial Policy outlined by The Institute of Plastic, Reconstructive and General Surgery. I understand and agree that regardless of my insurance status, I am responsible for the balance on my account for any medical services provided.

____

Signature – Patient/Guarantor   Date

Consent for Treatment - I hereby give consent to the physicians and staff at The Institute of Plastic, Reconstructive and General Surgery to provide healthcare services as deemed appropriate for my diagnosis. The signature below is indication of my consent.

____

Signature – Patient/Guarantor   Date

Read and Sign – Assignment of Benefits – Authorization to Release Medical Information – Notice of Privacy Practice

Assignment of Benefits - I authorize payment of medical services be paid directly to The Institute of Plastic, Reconstructive and General Surgery on my behalf for any services rendered.

Authorization to Release of Medical Information - I authorize The Institute of Plastic, Reconstructive and General Surgery to release medical information needed to determine benefits payment for related services.

Acknowledgement of Notice of Privacy Practice: A complete description of how my medical information will be used and disclosed by The Institute of Plastic, Reconstructive and General Surgery is in the "Notice of Privacy Practice" and has been provided to me.

____

Signature – Patient/Guarantor   Date

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MEDICAL HISTORY   **Date: __________**

Name: ____ **Date of Birth:** ______________________ **Age:** ___________

Height: ___________ **Weight:** ___________ **Blood Pressure:** ___________ **Pulse:** ___________ **Respirations:** ___________

Date of last menstrual cycle: ____

Reason for seeing doctor today: ____

What makes the problem better: ____

What makes the problem worse: ____

Has any testing been done: ☐ X-rays ☐ CT Scan ☐ MRI ☐ Ultrasound ☐ Mammogram ☐ HIDA Scan

☐ Colonoscopy ☐ Biopsy ☐ Other ______________________

When and where was testing done: ____

What treatments have you had for the problem we are seeing you for today: ______________________________________

____

List all allergies: ____

____

Are you allergic to latex: ☐ Yes ☐ No

Are your parents living: Mother ☐ Yes ☐ No Father ☐ Yes ☐ No **Are your siblings living:** ☐ Yes ☐ No

SOCIAL HISTORY

Do you smoke cigarettes?	☐ Yes	☐ No	If yes, how many packs a day? ______________
Have you ever smoked cigarettes?	☐ Yes	☐ No	When did you quit? ______________
Do you consume alcohol?	☐ Yes	☐ No	If yes, how much per day? ______________
Do you use illegal drugs?	☐ Yes	☐ No	If yes, what drugs? ______________
Do you have a history of drug or alcohol abuse?	☐ Yes	☐ No	
Do you consume caffeinated beverages?	☐ Yes	☐ No	If yes, how much per day? ______________
Do you take vitamins or supplements?	☐ Yes	☐ No	If yes, what type? _______________________
Do you exercise?	☐ Yes	☐ No	If yes, how often? _______________________

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform my doctor's office of any changes in my medical status.

____   ____

Patient or Guardian Signature   Date   **Physician Signature   Date**

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Patient Name:____ **Date of Birth:**________________________

Personal Medical History:

Pharmacy Name: ____ **Phone Number:**____________________________________

	Medication	Dose	Frequency	Prescribing Physician
1				
2				
3				
4				
5				
6				
7				
8				

Previous Surgeries/Hospitalizations	Year	Physician	Hospital

Personal Medical History: CIRCLE any of the conditions listed that have ever been a problem for you:

Acid Reflux	Jaundice	High Cholesterol	Pneumonia
Colitis	Blood Clots	Lung Disease	Stroke
Heart Disease	Diverticular Disease	Cancer	Seizures
Irregular Heart Beat	High Blood Pressure	Gallbladder	Thyroid Disease
Anxiety Disorder	Liver Disease	HIV/AIDS	Dialysis
Depression	Blood Transfusion	Musculoskeletal Issues	Psychiatric Disorders
Hiatal Hernia	Diabetes	Kidney Disease	Other: _____________

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Patient Name: ______________________________ **Date of Birth:** ____________________

Review of all Health Systems: CIRCLE any conditions you have had in the last 6 months:

Weight gain/loss more than 10 lbs

Fever

Night Sweats

Chills

Marked Fatigue

HEAD:

Headache

Facial Pain

Sinus Pain

EYES:

Blurred/Double Vision

Eye Pain

Light Sensitivity

EAR/NOSE:

Earache

Hearing Loss

Nose Bleed

Hoarseness

Throat Pain

NECK:

Neck Pain

Neck Stiffness

Lump/Swelling Neck

BREAST:

Pain

Discharge

Lump

CARDIOVASCULAR:

Chest Pain/Tightness/Pressure

Fast Heart Rate

Palpitations

PULMONARY:

Shortness of Breath

Recurrent Cough

Coughing up Blood

Wheezing

GASTROINTESTINAL:

Appetite Change

Difficulty Swallowing

Heartburn/Indigestion

Nausea

Vomiting

Recurring Abdominal Pain

Diarrhea

Blood in Stool

Constipation

UROLOGICAL:

Difficulty Urinating

Increased Urinary Frequency

Blood in Urine

Pain/Burning on Urination

Incontinence

Urinary Tract Infection

SKIN:

Skin Lesions

Rashes

Skin Change

ENDOCRINE:

Excessive Thirst

Change in Sex Drive

Jaundice

Cold Intolerance

Heat Intolerance

Tiredness

NEUROLOGICAL:

Dizziness/Vertigo

Seizures

Tremors/Numbness

Sensory Disturbances

PSYCHOLOGICAL:

Difficulty Sleeping

Anxiety

Depression

HEMATOLOGICAL/Lymphatic

Bruise Easily

Enlarged Glands

REPRODUCTIVE SYSTEM:

Other: ____________________

Any other information your doctor may need to be aware of? ______________________________

____

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Welcome to our practice. Thank you for choosing us for your surgical needs.
Enclosed is the New Patient Registration Paperwork necessary for our doctors to adequately provide care to you.
Please complete each page in its entirety and bring it with you to your appointment.

For your convenience we have made a check list of items you need to bring to your appointment. These items assist our staff with your care.

CHECK LIST

Do I have the following for my appointment?

- ☐ **PHOTO ID**
- ☐ **INSURANCE CARD(S)**
- ☐ **LIST OF MEDICATIONS**
- ☐ **XRAY, MRI, OR CT FILMS**
- ☐ **COMPLETED PAPERWORK**
- ☐ **CO-PAY, CO-INSURANCE, DEDUCTIBLE**

Thank you,

We look forward to meeting you.